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Minutes: Payment Implementation Workgroup

April 27, 2011, 1:00 PM

Attendees:

Name	Organization
Lisa Dulsky Watkins	Blueprint
Beth Tanzman	Blueprint
Pat Jones	Blueprint
Randy Messier	Fletcher Allen Health Care
Sarah Narkewicz	Rutland Regional Medical Center
Laura Hubbell	Central Vermont Medical Center
Laural Ruggles	Northeastern Vermont Regional Hospital
Dana Noble (phone)	United Health Alliance
Maria Webb (phone)	Brattleboro Memorial Hospital
Tracey Paul (phone)	North Country Hospital
Nancy Thibodeau (phone)	Springfield Hospital
LaRae Francis (phone)	Gifford Hospital
Lou McLaren	MVP
Gerhild Bjornson	CIGNA
Kevin Ciechon	CIGNA
Michele Corey (phone)	CIGNA
Chrissie Racicot	HP
Jennifer Farley	HP
Jocelyn Ferdinand	HP
Terri Mitchell	HP
Carol Cowan	BCBSVT
Scott Frey	BCBSVT

1. Status of Roster Submissions for New Practices and NCQA Recognition: The CVMC practice rosters were sent to the payers a couple of months ago, and Cold Hollow Family Practice's roster was sent to the payers on April 26. Lou noted that the Cold Hollow roster was missing the MVP and CIGNA ID numbers, and indicated that it was important to obtain fully completed rosters, especially given the rapid expansion beginning in July. Several members observed that the roster template was still under development, which made completion challenging. Lisa and Pat replied that the decision was made in this case to send out the roster without the information, because it would be readily available to the insurers, but that the intent is to submit fully completed rosters. Randy indicated that he gives the roster template to practices well ahead of time and works with them to ensure that all of the fields are completed.

CMS sent its roster template to the Blueprint on April 26; that document will be crosswalked with the Blueprint roster template. Lisa noted that CMS is trying to work with states' systems.

There was a discussion of when practices can expect PPPM payment after they have submitted their rosters and received their scores, how frequently they will be paid, and whether the payment will be retroactive to the VCHIP scoring date. Sarah asked which payers are sending separate checks for CHT and PPPM payments. The payment methodology spreadsheet will be updated with this information.

Randy noted that it is very helpful when the supporting documentation from the payers delineates CHT and PPPM payments.

Laural asked about the definition of adult and pediatric patients under the Practice Demographics tab of the roster template. Pat suggested that adult patients are those ages 22 or older, with the possibility of adding an additional column for ages 19 through 21. The practice managers advised against adding an additional column, and suggested that the age for adults should start at 19.

2. MOU for CHT and PPPM Payments: The current MOU is specific to the pilot practices, and needs to be updated. Pat reported that it is in draft form, and that it will need to be reviewed by DVHA legal staff. The payers indicated that they did not need standard language for contracts with providers; the PPPM payments will be handled under existing contracts, and the payers will rely on their legal counsel for language. Payers will need agreements with the CHT entities. Sarah asked about CHT funding mechanisms and how that impacts the ability to staff up for CHTs. Dana asked for guidance about how to approach the agreement when the hospital is not the CHT entity. Work will continue on the MOU, and work group members will be updated at the next meeting.

3. CHT Formula and Pro-rating: The current formula allocates funding for a 0.5 FTE CHT staff member for every 2000 patients. Potential approaches for allocating patients to CHTs and determining payer funding shares will be discussed at a future meeting.

4. CHT and PPPM Payment Processes: How They are Working and Issues From Practices: Project managers asked when payment changes are implemented as practices are rescored. For initial practice scoring, PPPM payments occur from the date of VCHIP's initial score. For subsequent scoring, PPPM payments are changed on the first of the next month after NCQA's score is received (NCQA e-mails the score to the practice).

   VCHIP has indicated that the five new Fletcher Allen practices will be scored by June 1, and the remaining practices with a July 1 start date will be scored by July 1. The payers noted that it was important to obtain rosters for the July 1 practices by mid-May at the latest. LaRae indicated that the rosters for the Randolph HSA practices are almost complete.

Laural said that the PPPM payments are happening as expected. Randy and Laural noted that although the practice and payer patient lists don't completely match up, it would be too much work to determine which patients are self-insured (which accounts for some of the variation between lists). They do look at total numbers of patients as a way of monitoring the lists. Lou asked whether practices need the patient lists from the insurers. Most of the payers send these lists monthly; Lou wondered if they could receive them less frequently. Randy and Laural said that they would ask whether some of the more experienced practices still needed them; Laura indicated that her practices would probably still want them (particularly the newer practices). There seemed to be consensus among the project managers that at least initially the patient lists should be provided, and that total numbers of patients would definitely be needed. The work group discussed potentially surveying practices and/or project managers to see if they needed them.

5. Impact of Scenarios on Attribution: The issue of "snowbirds" was discussed. Each payer outlined the impact on attribution. For MVP, Lou said that HMO members who see an out-of-state provider are not an issue. Those members select PCPs, so attribution is relatively clear. But PPO members can be an issue; if they see a PCP in another state (or a provider who is not part of a Blueprint practice), they fall off the roster. For CIGNA, Kevin indicated that members stay on the roster unless they see another provider in Vermont who is not part of a medical home. For Medicaid, Chrissie reported that members stay on the roster if during the past 12 months there has been a claim from a provider at a Blueprint practice with an E & M code or an immunization. BCBSVT outlined their six-step attribution algorithm (if there is more than one PCP, the patient is attributed to the PCP with the most visits, the most primary care services, the most recent visit, or the highest claims amount).

   The issue of what happens to patients when their physician leaves a practice also was discussed. MVP's HMO members have to select a PCP; the practice can also ask MVP to assign the patient to another provider in the practice. There is no clear answer for MVP's PPO members; a provider's exit could lead to a loss of membership. Chrissie gave an example of a physician who moved from one practice to another; HP end-dated the provider a year unto the future. If the member saw another PCP, they were switched to that provider. BCBSVT agreed that the issue is really for members that don't have to select a PCP; they sometimes require practices to reassign members. All agreed that the expansion will exacerbate the issue and that practices need to be part of the solution. The insurers agreed to bring possible solutions to the next meeting.

6. Legislative Update: H. 202 has now passed the Senate with some changes to the House version; the differences will be resolved in conference committee.

Next Meeting: Tuesday, May 10, 2011
1:00 to 2:00 PM
Conference Call
Dial In: 1-888-394-8197
PIN: 313409